AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Michigan Department of Community Health

Instructions to FAMILY:

- Please complete this form and retain the PINK copy for your records.
- Send the WHITE and YELLOW copies to the specialty doctor, hospital, or clinic treating the person who is seeking CSHCS coverage.

Instructions to PROVIDER:

- Retain the WHITE copy for your records.
- Attach the YELLOW copy of this form to the most recent comprehensive medical information (not more than 12 months old) related to the diagnosis(es) requiring specialty care and mail all to:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CSHCS DIVISION
PO BOX 30734
LANSING MI 48909-8234

Patient's Name			Date of Birth		
Patient Address (Number and Street)			CSHCS/ Medicaid ID Number		
City	State	ZIP Code	County		
Parent/ Guardian Name			Parent/ Guardian Phone Number		
Parent/ Guardian Address (If Different Than Child's)			City	State	ZIP Code

I authorize

_____

(Name of Specialty Doctor, Hospital, or Clinic)

located at

_____

(Complete Address of Specialty Doctor, Hospital or Clinic)

to release the most current medical information (from the past 12 months), which may include medical reports, letters from physician specialists, office or hospital inpatient or outpatient summaries that review status of medical problems and ongoing treatment plans, to the Michigan Department of Community Health, Children's Special Health Care Plan Division or their agents for the purposes of determining program eligibility. These records may include any information about Human Immune Deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC); as defined by the Michigan Department of Community Health.

I understand that if I give permission, I have the right to change my mind and revoke it. This must be in writing to you. I understand that if this authorization is required as a condition of demonstrating criteria for eligibility in the CSHCS program and I revoke the authorization, then CSHCS has a right to contest my claim(s). I also understand that I cannot take back any uses or disclosures already made with my permission.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services or eligibility unless the information is necessary to demonstrate that I meet the criteria required to establish eligibility.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal privacy rules. I further understand I may request a copy of this signed authorization.

Unless revoked, this authorization expires 12 months from the date signed.

Signature of Patient, Parent or Legal Guardian	Date Signed	Signature of Witness (any Adult over the age of 18)	Date Signed

AUTHORITY: Public Act 368, P.A. of 1978 COMPLETION: Is Voluntary	The Department of Community Health is an equal opportunity employer, services and programs provider.

MSA-0838 (Rev. 09-03) Previous editions obsolete.

COPY DISTRIBUTION: WHITE - Provider
YELLOW - CSHCS
PINK: - LHD/ Family